Iowa Medicaid Enterprise

Medicaid State Innovation Model (SIM) Learning Session

Our national health care delivery system is a fragmented, procedure based business model that pays for sick care

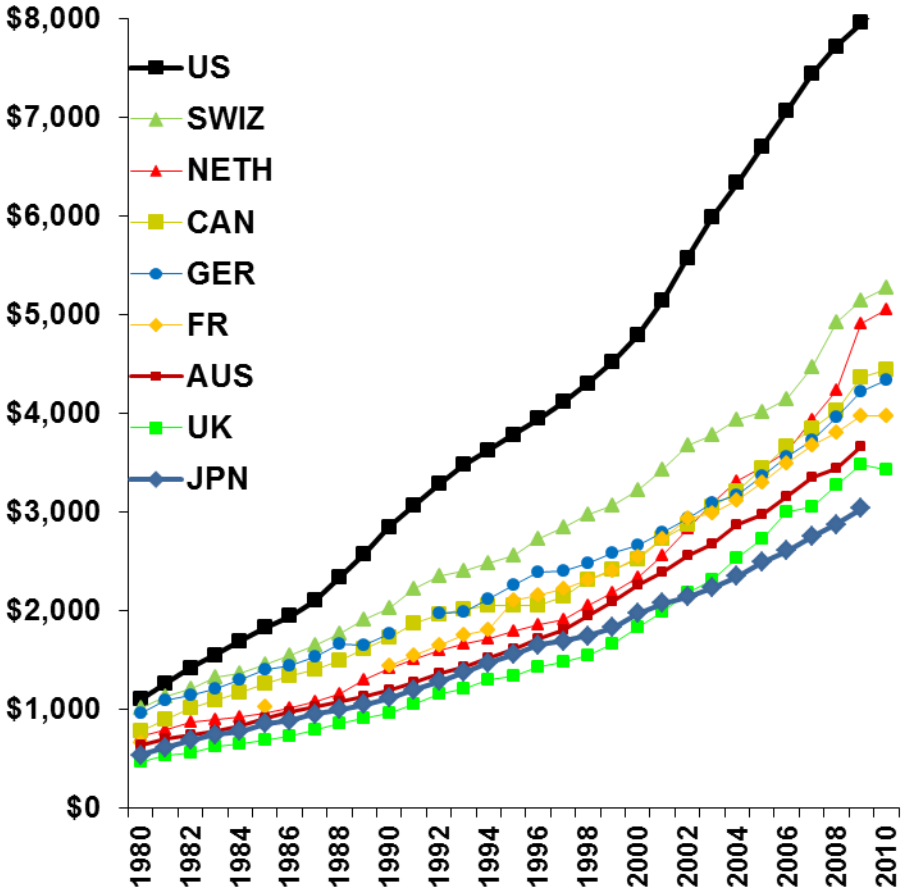
It was <u>not</u> built to <u>reward</u> wellness

Accountable Care

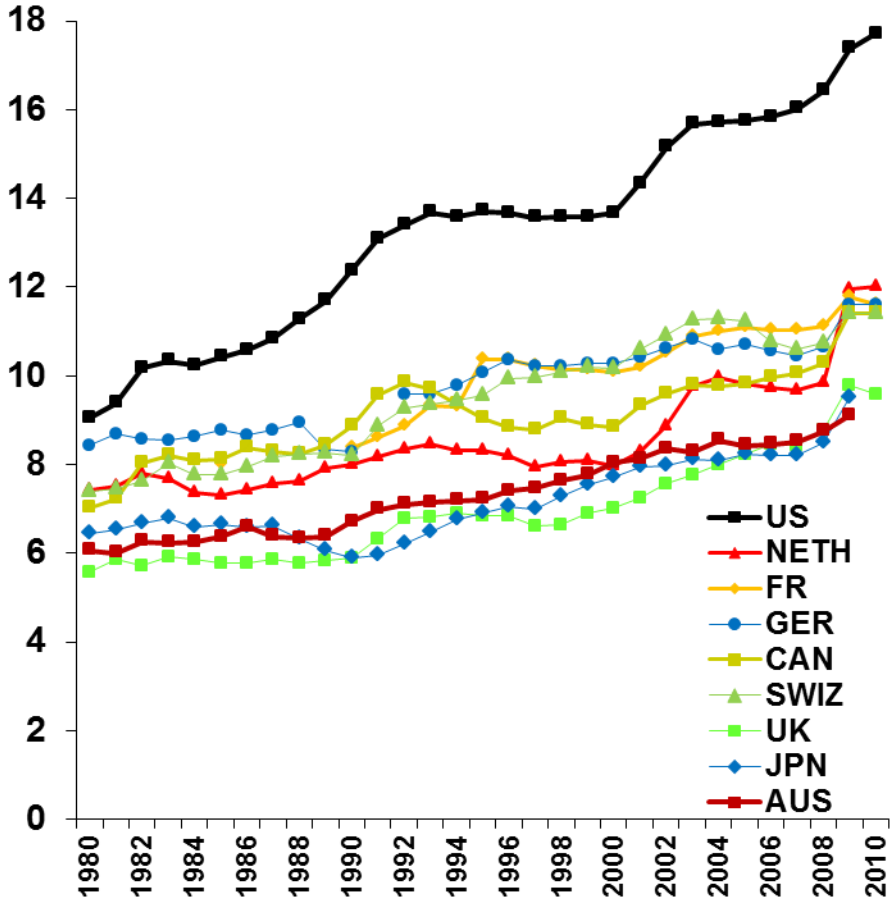
Accountable Care Organizations (ACO) are designed to *empower* the health care delivery system to control the resources and gain the rewards of *managing the health* of *all* populations across *all* settings.

Not “news” per se – but you really can’t ignore this

Average spending on health per capita ($US PPP)

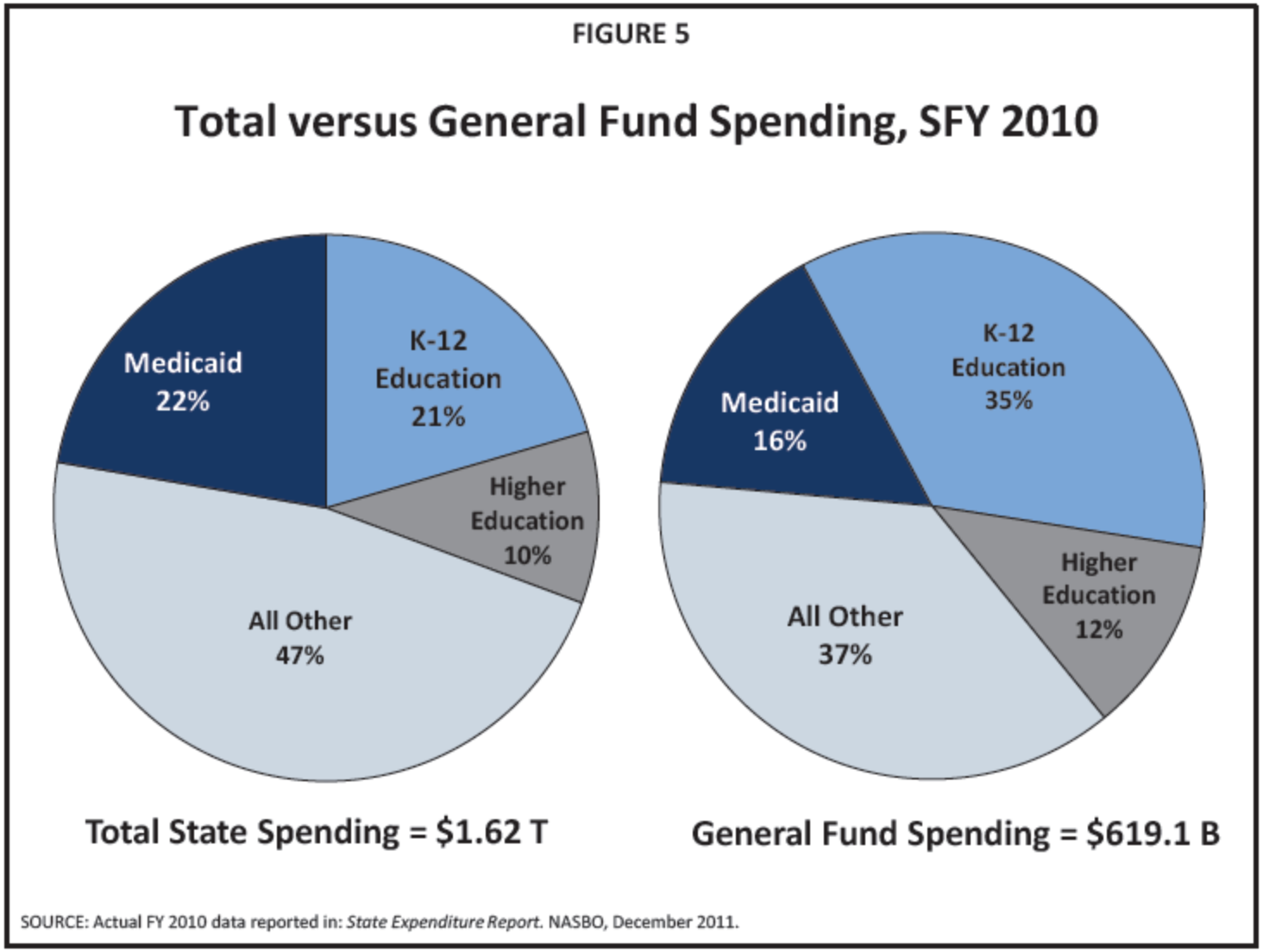


Total health expenditures as percent of GDP



Notes: PPP = purchasing power parity; GDP = gross domestic product.
Source: Commonwealth Fund, based on OECD Health Data 2012.

Impact on State Budgets is Material



What is an ACO?

Accountable care organization

From Wikipedia, the free encyclopedia

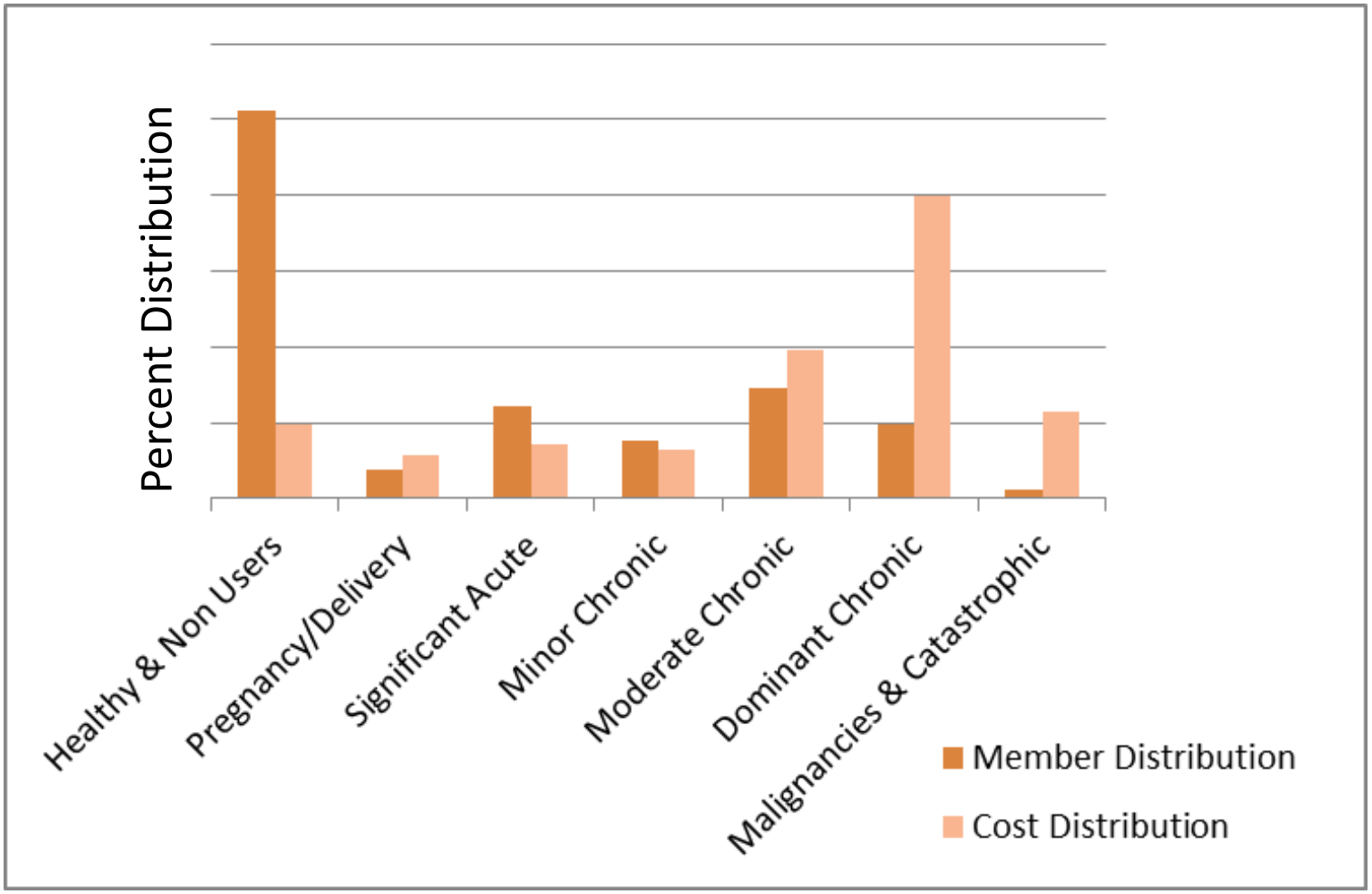
An **accountable care organization** (ACO) is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. A group of coordinated health care providers forms an ACO, which then provides care to a group of patients. The ACO may use a range of payment models (capitation, fee-for-service with

"…characterized by a payment and delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population…"

More importantly – how will it solve our problem?

- Align payment with wellness and population health – not sick care
- Provide funding for delivery systems to redesign themselves
- Empower providers to care for patients across entire continuum of care
- Creates environment for innovation

Opportunity: Chronically ill patients drive a disproportionate share of the costs

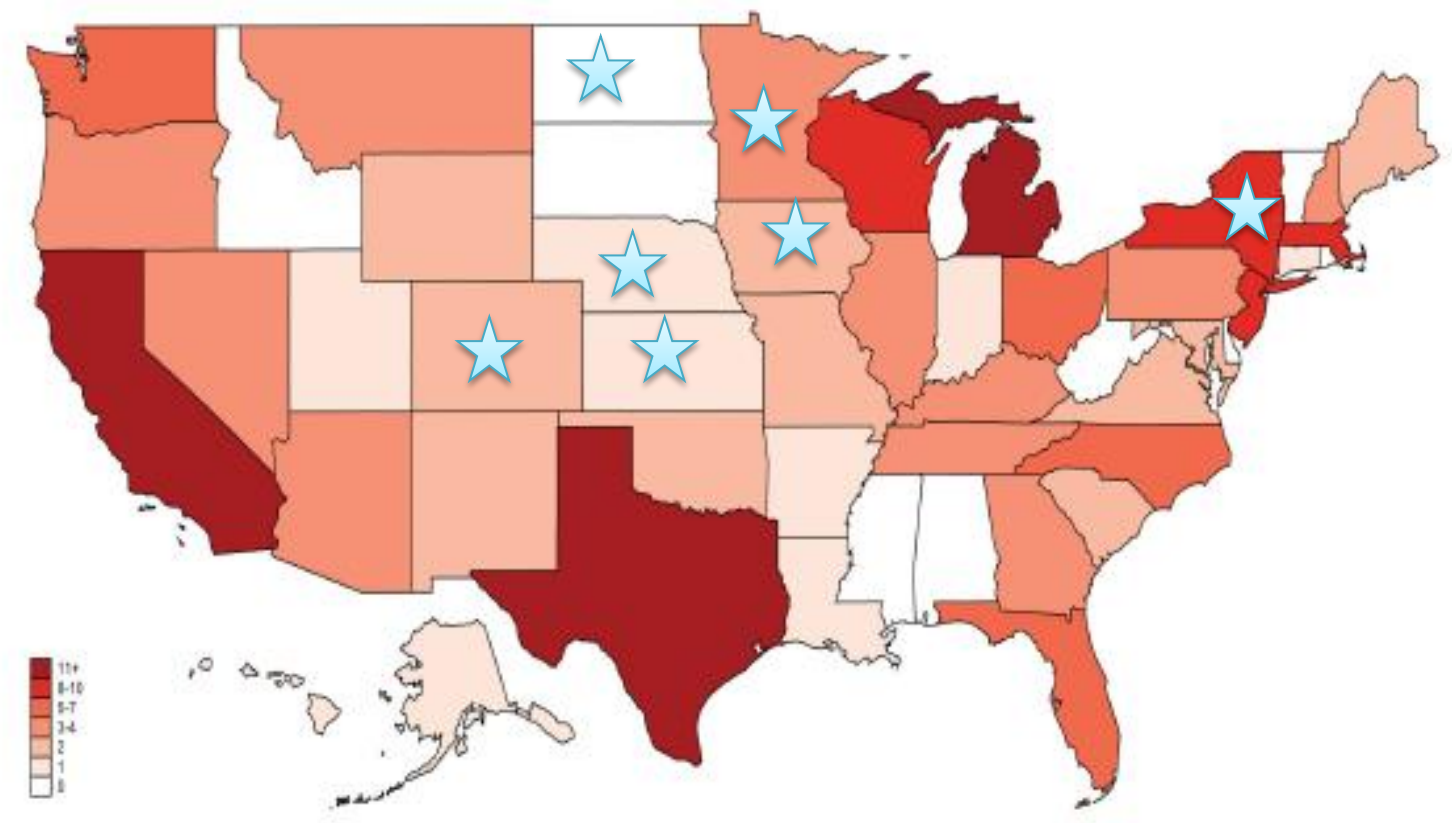


In Iowa the top 5% High Cost/High Risk Members* Accounted For:

- 90% of hospital readmissions within 30 days
- 75% of total inpatient cost
- Have an average of 4.2 conditions, 5 physicians and 5.6 prescribers
- 50% of prescription drug cost
- 42% of the members in the top 5% in 2010, were also in the top 5% in 2009.

*Excludes Long Term Care, IowaCare, Dual Eligibles, and maternity

National view of ACO Distribution

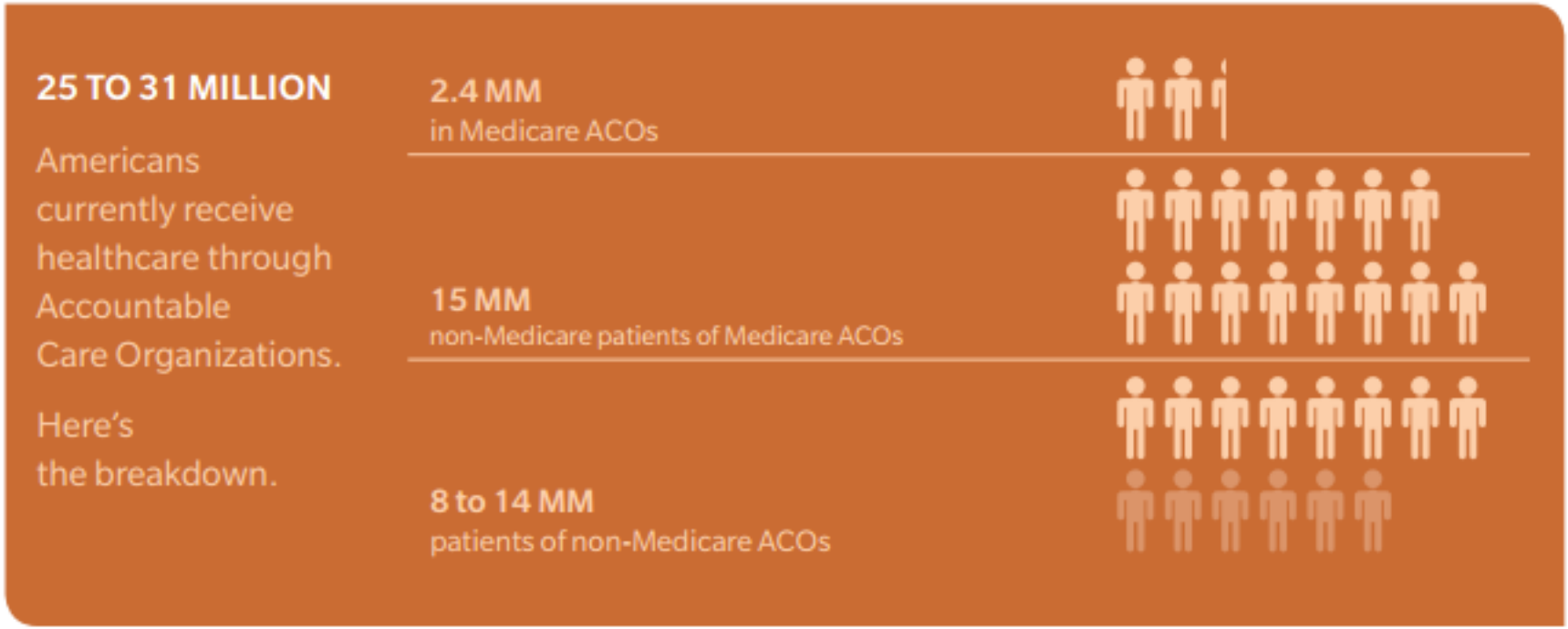


Leavitt Partners – Center for ACO Intelligence

Treo Clients

ACO prevalence is increasing – no longer a “unicorn”

More than 40% of Americans live in primary care services areas with at least 1 ACO



Source: Oliver Wyman, *“The ACO Surprise”*

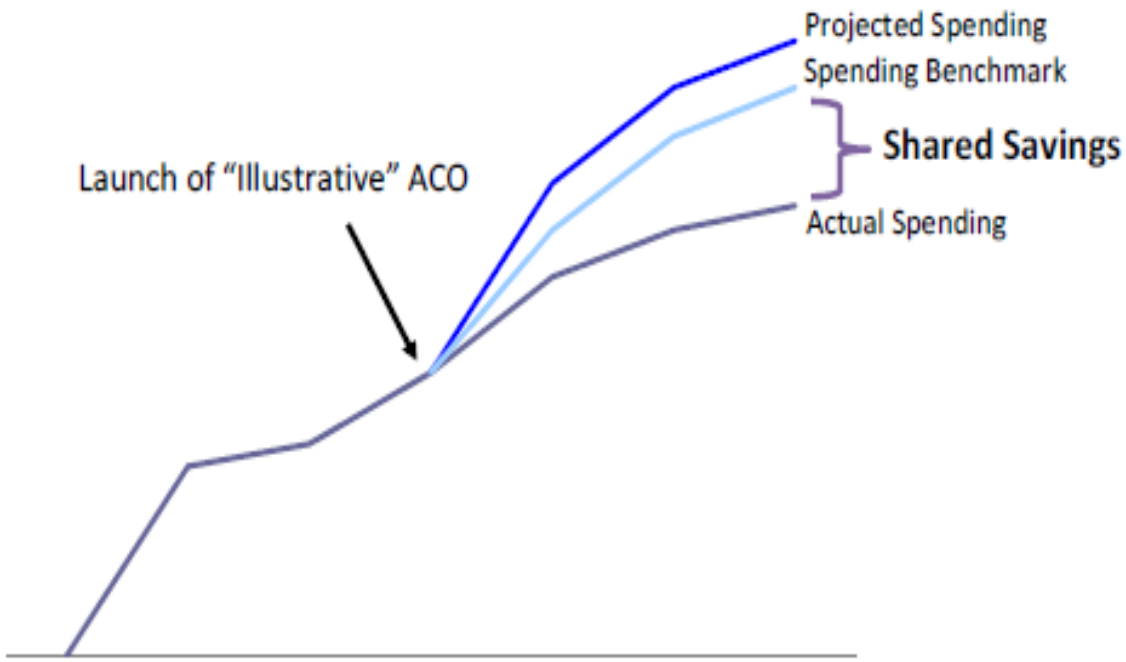
Requirements for Success

- Alignment in Incentives
- Organized Infrastructure
- Accountability for Performance
- Actionable, Timely and Meaningful Data
- A Person centered approach, and
- Scale

Aligned Incentives Needed to Fuel Transformation

Figure 2

Shared Savings Derived from Spending Below Benchmarks That Are Based on Historical Spending Patterns



Source: issue brief accountable care organizations – Engelberg Center for Health Care Reform at Brookings and Dartmouth Institute for Health Policy and Clinical Practice – March 2009

Organized Infrastructure

- Design may vary but all flavors require ***appropriate access*** and ***mix*** of key ***providers***
  - This is critical for Medicaid programs considering including special needs populations in their ACO model.
- Organizational models may include:

- Physician group practice
- Integrated Delivery Systems
- Academic Health Systems
- Community Hospitals
- Federally Qualified Health Centers
- Long Term Care Systems

Collaboration of these systems, other provider groups as well as community based organizations

(e.g. Colorado model)

Accountability for Performance

Drivers of Accountability

- Patient Attribution
- Budget Development
- Payment models and incentives; and,
- Performance Measurement

Attribution – Defining the population for whom the ACOs are accountable

- Starts with the engagement of a broad set of stakeholders
- Needs to consider comprehensive array of health and social services
- May include multiple types of providers that see high-need, high-cost beneficiaries
- The planning is just beginning

Measuring Performance: Value

QUALITY / COST = VALUE

Measuring Performance: Cost

- Total Cost of Care
  - Variance from a budget
- Possible Preventable Events
  - Admissions
  - Re-Admissions
  - Services
  - ER Visits
- Utilization
  - Rate of prescriptions
  - % Generic

Measuring Performance: ACO Quality Metrics

IME will continue to review specific quality metrics (for hospitals, SNFs, home care, etc). In addition we will be tracking measures related to the way care is delivered.

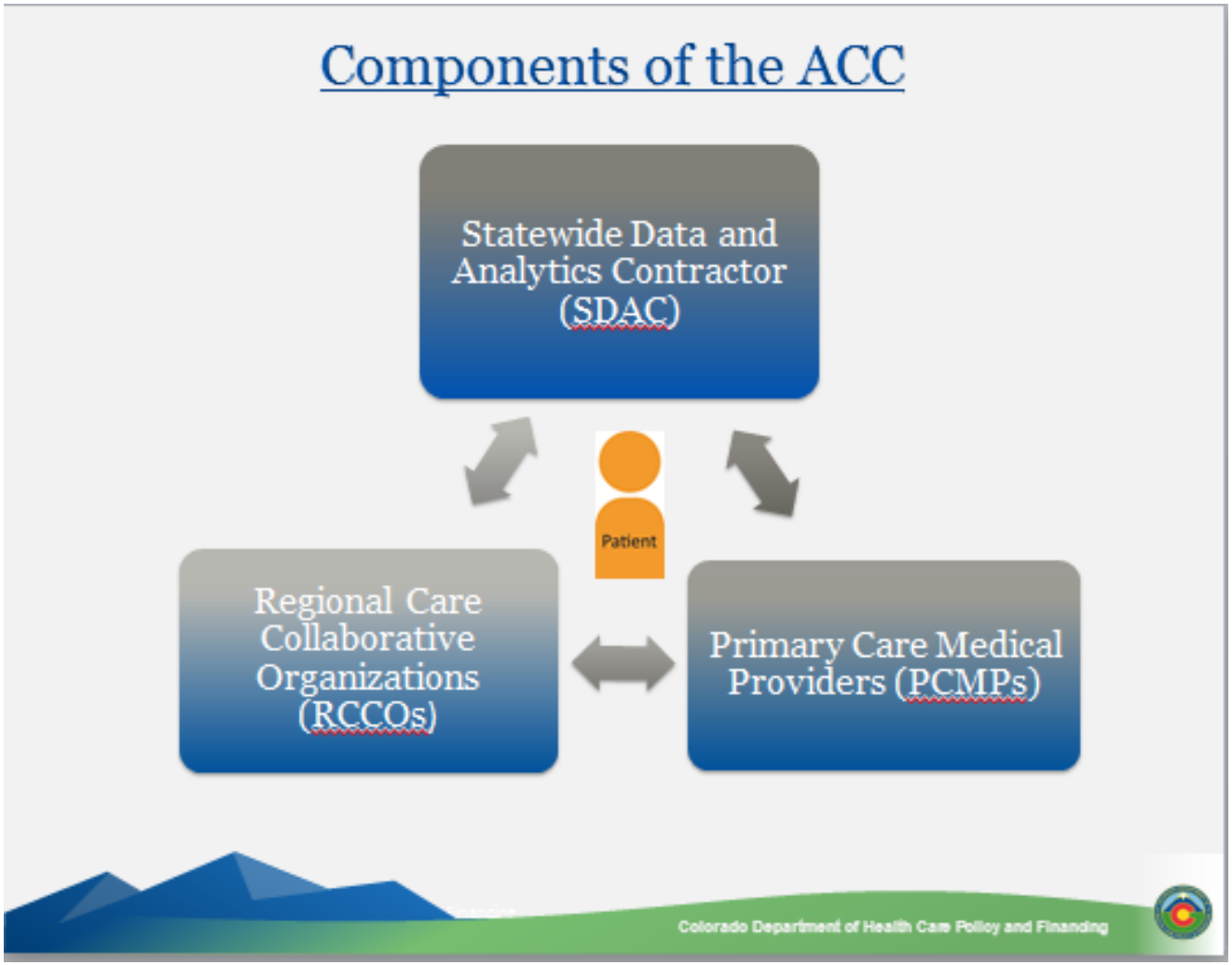
Consistent with the Wellmark model:

- Member experience
- Primary and secondary prevention
- Tertiary prevention
- Continuity of care
- Chronic and follow-up care
- Population health status
- Efficiency

AND

- TBD: Measures Specific to the Medicaid population, determined in conjunction with the stakeholders

Accountability in Colorado



- Went live in May 2011
- Includes 230K Medicaid Beneficiaries
- Favorable first year results

First Year Colorado Results

- Estimated gross savings: $9 - $30 million
- Administrative costs: ~$18 million (care management fee)
- When compared to non-ACC enrollees:
  - 8.6 percentage point reduction in hospital readmissions
  - Lower rate of increase in ER visits
  - Use of MRIs and other high-cost imaging decreased three percentage points
- Lower rates of preventable hospitalizations for enrollees with diabetes and asthma

Actionable and Timely Data

> **"WHAT GETS MEASURED GETS MANAGED"**
>
> PETER DRUCKER

- Getting the right metrics in the right hands requires:
  - Transparency
  - Collaboration
  - Actionability

Person Centered Approach

Core features of person-center care:

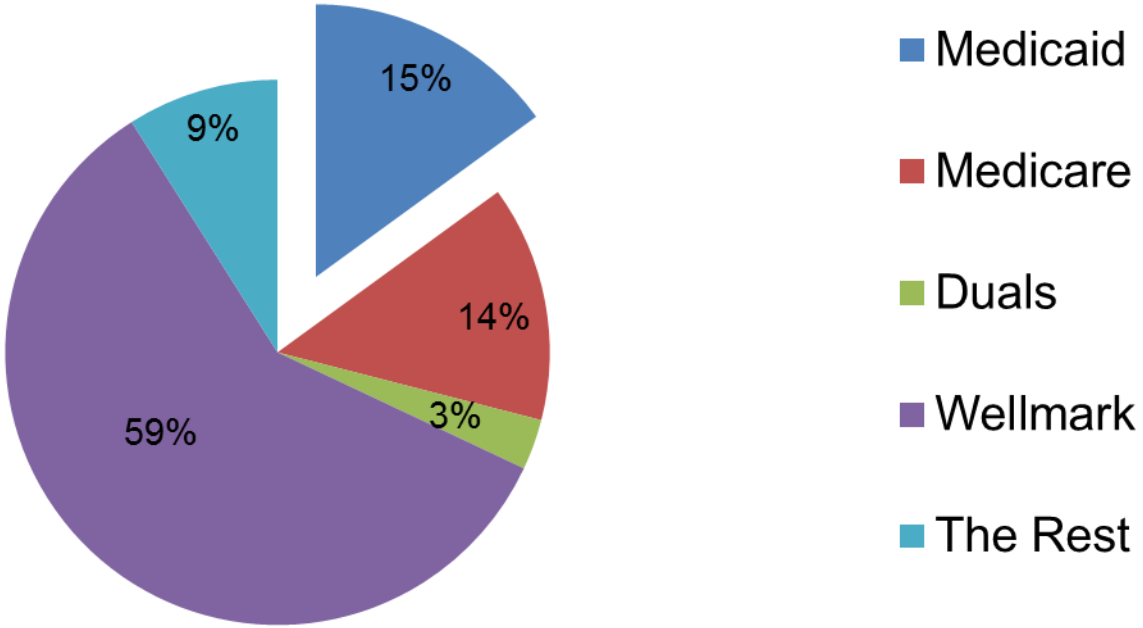
1. Access
2. Whole person care / continuity
3. Comprehensiveness
4. Care coordination

Primary care transformation is defined by the ability to achieve threshold improvement on all four attributes

Regardless of the population – these features of primary care must be in place

Getting to Scale

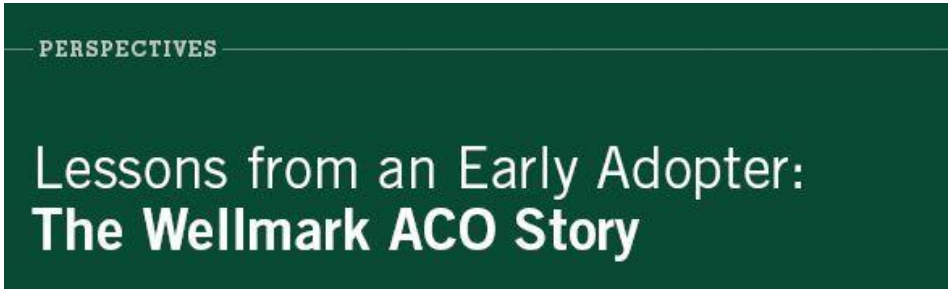
- The sustainable transformation of the health care delivery system requires scale
- Medicaid alone as a payer is not big enough to accomplish needed reform
- Plan requires a multi payer approach



Leverage investments made…

Wellmark has blazed the trail by:

- Engaging the providers in the development of the ACO process
- Emphasizing transparency by sharing information on fees and pay rates
- Providing Strategic Opportunity Analysis to each ACO to help them prepare for and manage their new ACOs
- Providing Tools for Insight in the form of network/provider/patient dashboards and reports that contain continuous near time, actionable information for improving care and lowering costs



But don’t ignore the differences

- Medicaid population as a whole is different from the insured Wellmark population
- Medicaid population has significant variation in needs across all programs
- SIM Planning will consider needs of each population.
- Working with stakeholder groups SIM planning will evaluate model design impact to ensure care continues to be delivered in the appropriate setting and the appropriate time by the appropriate care giver.